DECLARATION OF MAXWELL KADEL

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	No. 1:19-cv-00272-LCB-LPA **DECLARATION OF MAXWELL KADEL**

I, Maxwell Kadel, hereby state as follows:

1. I am a plaintiff in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

2. I am a 38-year-old transgender man. I was employed by the University of North Carolina at Chapel Hill ("UNC") from October 2016 to November 2019. After working for a different employer since November 2019, I returned to work at UNC in October 2021. I live in Chapel Hill, North Carolina.

3. I was designated female at birth but have a male gender identity. I live all aspects of my life in accordance with my male gender identity.

4. I began working with the UNC School of Government in October 2016, where I worked as an Administrative Support Associate until I accepted another job opportunity outside the University system in November 2019. In October 2021, I returned to UNC as a Software Applications Developer in the UNC University Libraries system.

5. While working at the UNC School of Government, as a North Carolina state employee, I was enrolled in the North Carolina State Health Plan for Teachers and State Employees ("NCSHP"), and I received health care benefits from this plan as part of my compensation. I contributed each month to the plan via a paycheck deduction.

6. I have struggled with gender dysphoria since childhood, and was diagnosed with gender dysphoria at the age of 33.

7. As part of my prescribed treatment for gender dysphoria, I began hormone therapy in June 2016.

8. While I was working at the UNC School of Government, I lived with significant distress caused by gender dysphoria. This included distress and anxiety about how people treated me with regard to my gender, and discomfort with my physical appearance and with being seen as a woman.

9. Because of the NCSHP's categorical Exclusion of coverage for gender-confirming health care, my insurance did not cover my hormone therapy and I was forced to pay for it out of pocket.

10. On October 29, 2018, CVS issued a Notice of Determination ("ND") denying prior authorization for coverage of my testosterone prescription. A true and correct copy of the ND is attached as Exhibit A. The ND explained that the prescription would only be covered for males with "primary or hypogonadotropic hypogonadism," and that because my "use of this drug d[id] not meet th[is] requirement," it would not be covered. Exhibit A at 2 (KADEL00313153).

11. In 2017, after the NCSHP eliminated the Exclusion, I considered pursuing chest surgery to create a more typically masculine chest, but decided to wait and see whether hormone therapy would be sufficient to relieve my gender dysphoria.

12. In 2018, in consultation with my health care providers, I determined that chest surgery was necessary to alleviate my gender dysphoria, and was ready to move forward with further consultations leading to surgery. I then discovered that the NCSHP had reinstated the Exclusion, effective January 1, 2018, in all of its health plans.

13. After the Exclusion was reinstated in 2018, I was deprived of insurance coverage for medically necessary hormone therapy and gender-confirming surgical care. I paid out-of-pocket for hormone therapy. During that time, to lessen the financial burden of paying out-of-pocket for testosterone every month, I often rationed and used vials of testosterone past the expiration date.

14. I also had to forgo chest surgery, which caused me to experience significant gender dysphoria-related distress on a daily basis. I wore a binder to compress my chest, but it caused me physical discomfort and breathing difficulties. I also have asthma, which was exacerbated by having to bind my chest because I could not obtain a permanent medically necessary solution through surgery.

15. Eventually, I was able to save enough to undergo chest surgery in February 2021. Although the expense for surgery was substantial for me as an individual paying out-of-pocket—$10,525—surgery brought significant relief from my gender dysphoria and

the physical discomfort I had felt with my body. I now feel much more comfortable with my body.

16. Because I have returned to work at UNC, the Exclusion also prohibits me from seeking future medically necessary gender-confirming health care, such as ongoing hormone therapy and additional surgery I may need.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: 11/24/2021 Max Kadel

Maxwell Kadel

Subscribed and sworn before me, a Notary Public in and for the ORANGE COUNTY, State of NORTH CAROLINA, this 24 day of NOVEMBER, 2021.

KYLE F. HOOPES NOTARY PUBLIC ORANGE COUNTY, NC

Signature of Notary

Kyle F Hoopes

Exp: JANUARY 27, 2023

CERTIFICATE OF SERVICE

I certify that the foregoing document was filed electronically with the Clerk of Court using the CM/ECF system which will send notification of such filing to all registered users.

Dated: November 30, 2021

/s/ Amy E. Richardson

Amy E. Richardson
N.C. State Bar No. 28768
HARRIS, WILTSHIRE & GRANNIS LLP
1033 Wade Avenue, Suite 100
Raleigh, NC 27605-1155
Telephone: 919-429-7386
Facsimile: 202-730-1301
arichardson@hwglaw.com

Counsel for Plaintiffs

Exhibit A

CVS caremark

Fax Transmittal

To: MEMBER

From: CVS Caremark® Prior Authorization

Electronically (ePA) (4 to 5 **minutes** process time)	Phone (10 to 15 **minutes** process time)	Fax (24 to 72 **hours** process time)
ePA is CVS Caremark's preferred method for receiving prior authorizations and now accepts PA requests online 24/7. **Easier:** Reduce the need for paper forms, faxes, and phone calls **More Convenient:** Centrally manage ePAs and more easily view their status **Faster:** Generally receive faster determinations so patients can fill their medication sooner **Visit http://info.caremark.com/ePA to learn more and get started today.**	Calling us with your PA request during our business hours is another option. **See next page for the specific phone number.** The process over the phone can take between 10 and 15 minutes. OR see ePA option	You may also continue to fax us your PA request. **See next page for specific fax number.** Faxes received are processed within 24 to 72 hours. OR see ePA option

If this fax is in response to an inquiry about clinical criteria for coverage of a prescription drug for your patient, the criteria for the specific drug is attached.
Please note that your inquiry does not constitute a request for coverage. CVS Caremark cannot process a request for coverage until we receive a completed criteria form or appropriate clinical information.

91-41319A 062917

CVS caremark™

North Carolina State Health Plan FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

DALE R. FOLWELL, CPA

Notice of Determination

Date: 10/29/2018

MAXWELL KADEL
[redacted]

Plan Member Name: MAXWELL KADEL
Plan Member ID: ******[redacted]
Plan Name: North Carolina State Health Plan 0274 Non-Grandfathered

Prescriber Name: QUANG PHAM
Prescriber Phone: 1-9199428741
Prescriber Fax: 1-9199421473

Dear MAXWELL KADEL:

CVS Caremark® received a request from your provider for coverage of Testosterone Cypionate IM Injection. The request was denied because:

Your plan approved Testosterone Products criteria covers this drug when you have primary or hypogonadotropic hypogonadism. Your use of this drug does not meet the requirement. This is based on the information we have.

You can ask for a free copy of the actual benefit provision, guideline, protocol or other similar criterion used to make the decision and any other information related to this decision by calling Customer Care at **1-888-321-3124**.

For more information regarding your prescription benefit, please refer to your Benefit Booklet available on the Plan's website at **www.shpnc.org**.

If your provider would like to discuss this decision with a clinical reviewer at CVS Caremark, your provider can call CVS Caremark, and we will make arrangements for the conversation.

You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter. Please mail or fax your appeal to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

If your situation is urgent as defined by law, you may ask for an expedited appeal. Important information about your appeal rights and directions about how to ask for an appeal are provided with this letter.

If you have questions, please call Customer Care at **1-888-321-3124**.

Sincerely,

CVS Caremark

Enclosures

cc: Dr. QUANG PHAM

PA# North Carolina State Health Plan 0274 Non-Grandfathered 18-035548880 AG
Plan-approved Criteria: Testosterone Products
Claim Amount (if available):
Service Date: 10/25/2018 10:23:25 AM

If your provider included diagnosis or treatment codes with your claim for Testosterone Cypionate IM Injection to CVS Caremark, that information is listed here:
ICD diagnosis code: E34.9
Associated diagnosis: Endocrine disorder, unspecified
CPT treatment code:
Associated treatment:
You may wish to contact your provider for more information about these codes.

Important Information About Your Appeal Rights

What if I need help understanding this denial? You may contact CVS Caremark by calling **1-800-294-5979** if you need assistance understanding this notice or our decision to deny you a service or coverage.

What options does my provider have? If there is relevant information that has not been previously submitted, the treating physician may request a Provider Courtesy Review (PCR) by calling **1-800-446-8053 extension 52961** or by sending a written request within 180 days to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Provider Courtesy Review
PO Box 30055
Durham, NC 27702

What if I don't agree with this decision? You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702

A member appeal form is available on the Web at **www.BCBSNC.com**.

What if my situation is urgent? If your situation meets the legal definition of urgency, the review of your claim will be conducted within 72 hours, or earlier if required by law. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your situation is urgent, you or your physician may request an expedited appeal by contacting BCBSNC via mail or fax at the address below. In addition, you may have the ability to seek an expedited external review of your adverse benefit determination. To determine whether an external review process is available to you, please consult your benefit booklet or call BCBSNC customer service on the back of your ID Card.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level 1
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

Who may file an appeal? You or someone whom you name to act for you (your authorized representative) may file an appeal. A member consent form is attached for your convenience and is also available on our Web site at **www.BCBSNC.com**.

Can I provide additional information about my appeal? Yes. As part of the appeal process, you have the right to submit supporting materials in advance of a decision being made on your appeal.

What happens next? If you appeal, BCBSNC will review the decision and provide you a written determination within 30 calendar days. If the adverse benefit determination is overturned, BCBSNC will provide coverage or payment for your health care item or service. If the adverse benefit determination is upheld, you may have additional appeal rights.

How do I file a request for external review? You may be eligible for an external review process. To determine whether an external review process is available to you, please consult your benefit booklet or call BCBSNC customer service on the back of your ID card.

What other remedies do I have? Depending on your plan, you may also have the right to bring action under section 502(a) of ERISA. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

Can I request copies of information relevant to my adverse benefit determination? Yes. You may request and receive, at no cost to you, reasonable access to and copies of all documents, records and other information relevant to your claim by writing to:

Blue Cross and Blue Shield of North Carolina
Healthcare Management & Operations
P. O. Box 2291
Durham, NC 27702

This information may also include the following:

- Any internal rules, guidelines, protocols, or other criteria used to make this decision, including any clinical review criteria indicated above (please include the referenced medical policy from page 1 of this notice with your request); and/or
- If the decision is based on medical necessity, experimental treatment or another similar exclusion, an explanation of the scientific or clinical judgment for the determination, applied to your medical circumstances.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272)**. You may also receive assistance with appeals from Smart NC by contacting:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
1-855-408-1212 (toll-free)

External Review
North Carolina law provides for review of *adverse benefit determinations* by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. *BCBSNC* will notify you of your right to request an external review each time you receive:

- An *adverse benefit determination*, or
- An appeal decision upholding an *adverse benefit determination* or
- A second-level *appeal* decision upholding an *adverse benefit determination*.

You or someone whom you have authorized to represent you may request an external review.

In order for your request to be eligible for an external review, the NCDOI must determine the following:

- Your request is about a *medical necessity* determination that resulted in an *adverse benefit determination (i.e., a noncertification)*;
- You had coverage with *BCBSNC* when the *adverse benefit determination* was issued;
- The service for which the *adverse benefit determination* was issued appears to be a *covered service*; and
- You have exhausted *BCBSNC's* internal *appeal* review process as described below.

For a standard external review, you will have exhausted the internal *appeal* review process if you have:

- Completed *BCBSNC's* first- and second-level *appeal* review and received a written second-level determination from *BCBSNC*, or
- Filed a second-level *appeal* and have not requested or agreed to a delay in the second-level *appeal* process, but have not received *BCBSNC's* written decision within 60 days from the date that you can demonstrate that an appeal was filed with BCBSNC, or
- received written notification that *BCBSNC* has agreed to waive the requirement to exhaust the internal *appeal* and/or second-level *appeal* process.

External reviews are performed on a standard or expedited basis, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

Standard External Review
For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above.

If the request for an external review is related to a retrospective *adverse benefit determination* (an *adverse benefit determination* that occurs after you have already received the services in question), the 60-day time limit for receiving *BCBSNC's* second-level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal appeal process and have received a written second-level determination from *BCBSNC*.

Expedited External Review
An expedited external review may be available if the time required to complete either an expedited internal first- or second-level appeal review or a standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may file a request to the NCDOI for an expedited external review, after you receive:

- An *adverse benefit determination* from *BCBSNC* and have filed a request with *BCBSNC* for an expedited first-level appeal; or
- A first-level appeal decision upholding an *adverse benefit determination* and have filed a request with *BCBSNC* for an expedited second-level *appeal* review; or
- A second-level *appeal* review decision from *BCBSNC*.

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a first-level appeal or second-level appeal decision concerning an adverse benefit determination of the admission, availability of care, continued stay or emergency health care services.

If your request is not accepted for expedited review, the NCDOI may (1) accept the case for standard external review if you have exhausted the internal appeal review process; or (2) require the completion of the internal appeal review process and another request for an external review. An expedited external review is not available for retrospective adverse benefit determinations.

When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that need to be reviewed for the purpose of reaching a decision on the external review. For further information about external review or to request an external review, contact the NCDOI at:

(Mail)
By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll-Free Telephone: **1-855-408-1212**
www.ncdoi.com/smart

(In person)
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/Smart
Toll-Free Telephone: **1-855-408-1212**

The Healthcare Review Program provides consumer counseling on utilization review and appeal issues. Within ten business days (or, for an expedited review, within three business days) of receipt of your request for an external review, the NCDOI will notify you and your provider of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOI within 150 days of the written notice from BCBSNC upholding an adverse benefit determination (generally the notice of a second-level appeal review decision), which initiated your request for an external review. If the NCDOI accepts your request, the acceptance notice will include: (i) name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that BCBSNC has provided to the NCDOI; and (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial adverse benefit determination to the assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of BCBSNC's receipt of the acceptance notice (or, for an expedited review, within the same business day), BCBSNC shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the adverse benefit determination, appeal decision or the second-level appeal review decision. If you choose to provide any additional information to the IRO, you must also provide that same information to BCBSNC at the same time and by the same means of communication (e.g., you must fax the information to BCBSNC if you faxed it to the IRO). When sending additional information to BCBSNC, send it to:

(Mail)
Blue Cross/Blue Shield of North Carolina
Appeals Department
PO Box 30055
Durham, NC 27702

Questions? Do you need help in a different language or format? If you do not speak English or have special needs, oral interpretation and alternate formats of this notice are available, as is other assistance, by contacting us at the number on your State Health Plan ID card.

Spanish:
Si usted necesita asistencia o necesita hablar con alguien en Español, por favor llame al número gratuito de Servicio al Cliente ubicado en su tarjeta de identificación de beneficios.

Chinese (simplified):
如果您需要帮助，或需要同中国人讲话，请拨打您的福利卡上面的客户服务免费电话号码。

Tagalog:
Kung kailangan ninyo ng tulong o kailangan ninyong makipag-usap sa isang tao sa Tagalog, mangyari lamang na tumawag nang walang-bayad sa Serbisyo sa Kostumer sa numero na nakasulat sa inyong ID kard ng benepisyo.

Navajo:
Shíka at'ohwol ei doodaii' dinék'ehgo łą bi'chį haadeedziih nínízinígo, t'áá shǫǫdí, t'áá jíík'e ya ndaalníshí, ni naaltsoos bikáa'gi bi'chį hodiilniih.

Activity Report

Date/Time	10-29-2018	05:29:33 p.m.	Transmit Header Text	
Local ID 1	0000000000		Local Name 1	000

Completed Jobs : 1

No.	Job	Remote Station	Start Time	Duration	Pages	Line	Mode	Job Type	Results
001	402	CVS Caremark	05:24:06 p.m. 10-29-2018	00:05:04	10/10	1	EC	HR	CP2400

Abbreviations:

HS: Host send	PL: Polled local	MP: Mailbox print	CP: Completed	TS: Terminated by system
HR: Host receive	PR: Polled remote	RP: Report	FA: Fail	G3: Group 3
WS: Waiting send	MS: Mailbox save	FF: Fax Forward	TU: Terminated by user	EC: Error Correct